



District of Columbia State Innovation Model
HIE Technology Work Group: Meeting Summary

November 17, 2015
3:30 p.m. – 5:00 p.m.

Participants present (in person and/or via teleconference) [11]: Scott Afzal (CRISP), Chris Botts (DHCF), Joe Cullinan (Community Connections), Selwyn Eng (Mary’s Center/CCIN), Luigi LeBlanc (Zane Networks), Donna Ramos-Johnson (DCPCA), Shahid Shah (Netspective), Brendan Sinatro (DCHA), John Sumner (DHCF), Shelly Ten Napel (DHCF), and Constance Yancy (DHCF)

TOPIC	DISCUSSION
<u>Review of Care Profile Concept</u>	<ul style="list-style-type: none">• Idea of creating a “Care Profile” came from previous Care Coordination Work Group meeting discussions<ul style="list-style-type: none">➤ Single access point where care managers (or providers if they so choose) could view key, high-level pieces of information for patients, particularly those who are high utilizers➤ This would differ from the C-CDA Summary/Top Sheet, which would provide a more detailed level of clinical information to physicians/prescribers• Current version of the mock-up appeared to include the right level of information, although it would be beneficial to be able to conveniently access additional details if the user wished to do so<ul style="list-style-type: none">➤ List payers in the “Care Team Designation” section (or otherwise designate who the payers are)➤ Add a link connecting the user to the more comprehensive Continuity of Care (CCD) document (if available)➤ Show the last 12 months of claims data

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	<ul style="list-style-type: none"> ➤ Create an additional list of previous historical demographic information and when they were uploaded; this would help mitigate issues where the most recent information that has been uploaded is not in fact the most up-to-date; alternatively, designate a preferred data source (e.g., hospital data) that will supersede all other data sources (if is available) ➤ Include the ability to download all or some of the data captured 																										
<u>Types and Sources of Data</u>	<ul style="list-style-type: none"> • Overall, the data types and sources discussed were as follows: <table border="1"> <thead> <tr> <th>Data Type</th><th>Potential Data Source(s)</th></tr> </thead> <tbody> <tr> <td>1) Demographics</td><td>CRISP's Master Patient Index (MPI)</td></tr> <tr> <td>2) Care Team Designation</td><td>CRISP Physician Panel(s) subscriptions, Medicaid Claims, and potentially DOH Database</td></tr> <tr> <td>3) Hospital Utilization</td><td>CRISP ADT feed supplemented w/ Claims/Encounter data (past 3-6 months)</td></tr> <tr> <td>4) Ambulatory Utilization (ADT)</td><td>Same as above</td></tr> <tr> <td>5) Care Manager(s)/Care Plan(s) Info</td><td>Medicaid Enrollment data, iCAMS, and OB Authorization Form; others potentially include CRISP ADT and DOH Healthy Start Program</td></tr> <tr> <td>6) Housing Status</td><td>DHS's Database</td></tr> <tr> <td>7) Pharmacy/Medication(s)</td><td>Medicaid Claims and DC's PBM; SureScripts/Allscripts is also a possibility</td></tr> <tr> <td>8) Diagnosed Chronic Conditions</td><td>Medicaid Claims and CRISP Feeds</td></tr> <tr> <td>9) Immunization(s)</td><td>N/A – Unable to discuss at length</td></tr> <tr> <td>10) Risk Score</td><td>N/A – Unable to discuss at length</td></tr> <tr> <td>11) Laboratory(ies)/Radiology(ies)</td><td>N/A – Unable to discuss at length</td></tr> <tr> <td>12) Allergy(ies)</td><td>N/A – Unable to discuss at length</td></tr> </tbody> </table> • Several of the data types/sources above were discussed in more detail: <ul style="list-style-type: none"> ➤ <u>Demographics</u> – Data would populate from the last information uploaded into the system; there is no guarantee this information is in fact the most up-to-date; IAPD funds could be used 	Data Type	Potential Data Source(s)	1) Demographics	CRISP's Master Patient Index (MPI)	2) Care Team Designation	CRISP Physician Panel(s) subscriptions, Medicaid Claims, and potentially DOH Database	3) Hospital Utilization	CRISP ADT feed supplemented w/ Claims/Encounter data (past 3-6 months)	4) Ambulatory Utilization (ADT)	Same as above	5) Care Manager(s)/Care Plan(s) Info	Medicaid Enrollment data, iCAMS, and OB Authorization Form; others potentially include CRISP ADT and DOH Healthy Start Program	6) Housing Status	DHS's Database	7) Pharmacy/Medication(s)	Medicaid Claims and DC's PBM; SureScripts/Allscripts is also a possibility	8) Diagnosed Chronic Conditions	Medicaid Claims and CRISP Feeds	9) Immunization(s)	N/A – Unable to discuss at length	10) Risk Score	N/A – Unable to discuss at length	11) Laboratory(ies)/Radiology(ies)	N/A – Unable to discuss at length	12) Allergy(ies)	N/A – Unable to discuss at length
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	<p>to research a more accurate method to accessing up-to-date demographic data on patients</p> <ul style="list-style-type: none"> ➤ <u>Pharmacy/Medications</u> – Difficult to access a comprehensive medications list outside of claims data; other data systems gather this information manually via home visits ➤ <u>Immunizations</u> – A bi-directional feed housed within an EHR environment would be extremely valuable for providers; HL7 VXU would most likely be the best data format to use; however, it is unclear whether this type of information should be captured in the Care profile, or better served in a CCD ➤ <u>Allerg(ies)</u> – Could be consolidated from C-CDA's, but exact process is still unclear ➤ <u>Other Sources</u> – Some <i>DOH registries</i> capture specific patient-level data (e.g., cancer registries), although others only receive summary data; <i>Pre-adjudicated Claims data</i> could also be useful to providers, particularly those that are performing chronic care management <ul style="list-style-type: none"> • Potential pathways will be dependent on whether the source data is structured or unstructured • <u>Next Step(s)</u>: Create a wireframe design of how these potential data elements are housed and could be connected.
<p><u>Potential Database Architecture</u></p>	<ul style="list-style-type: none"> • Several options for collecting and/or accessing each type of data described above <ul style="list-style-type: none"> ➤ A federated model could be implemented using Application Program Interfaces (APIs) to query each data source upon request <ul style="list-style-type: none"> ▪ This model is limited in the level of data analytics that can be run, particularly at the population level ➤ Select data types could also be housed using a more centralized model framework <ul style="list-style-type: none"> ▪ Depending on the use case, there are concerns about the level of privacy and security that could be realistically implemented given the need for a single entity to steward such a data repository ➤ A hybrid model is a third option, which would use a combination of a peer-to-peer (P2P) architecture and API connections for smaller practices/providers <ul style="list-style-type: none"> ▪ DHCF would have to broker this effort to ensure equal access amongst all users